(X6) DATE:

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IP CODE:		
STATE LICENSE NUMBER: 025602 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				110 / 1111			
F 0000 F 0578 SS=E	Based on a Medicare/N State Licensure and Ciron April 20, 2023, it w North Skilled Nursing was not in compliance requirements of 42 CF Requirements for Long 28 PA Code, Common Term Care Licensure R	vil Rights survey con as determined that Y and Rehabilitation C with the following R Part 483 Subpart I g Term Care Facilities wealth of Pennsylva Regulations.	mpleted York Center 3, es and the nia Long	F 0578	TITLE:	(X6) DATE:	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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	TEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIE N OF CORRECTION (POC) IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395442			00	04/20/2023	
YORK NO REHABILI	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER SEE NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	Y ROAD	IIP CODE:		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0578	Continued from page 1			F 0578			
SS=E	483.10(c)(6)(8)(g)(12)(i)-(v Trmnt; FormIte Adv Dir \$483.10(c)(6) The right to r discontinue treatment, to pa participate in experimental advance directive. \$483.10(c)(8) Nothing in the construed as the right of the provision of medical treatm medically unnecessary or in \$483.10(g)(12) The facility requirements specified in 42 (Advance Directives). (i) These requirements inclusively written information concerning the right to accept treatment and, at the resider advance directive. (ii) This includes a written opolicies to implement advance tasks. (iii) Facilities are permitted furnish this information but ensuring that the requirements.	equest, refuse, and/or reticipate in or refuse to research, and to formula is paragraph should be resident to receive the ent or medical services of appropriate. must comply with the 2 CFR part 489, subpart to all adult residents pt or refuse medical or sut's option, formulate an elescription of the facility are directives and applicate to contract with other enteres are still legally responsi	te an deemed I and surgical y's able ntities to ible for		The statements made on this correction are not an admissi and do not constitute an agre with the alleged deficiency (herein. To remain in complia all federal and state regulation facility has taken, and will ta actions set forth in the follow plan of correction. The follow plan of correction constitutes center's allegation of complia alleged deficiencies cited has or will be corrected by the dates indicated. The facility committed to taking all action necessary to remain in substate compliance with state and feregulations. The plan of corrected or ur residents which enhances their dignity and is designed to meet their interepromote the highest practical of physical, mental, and psycho-social well-being.	ion to beement s) ance with ons, the ake, the wing wing s the ance. All we been, ate or is antial deral ection omote	Completion Date: 06/06/2023 Status: APPROVED Date: 05/03/2023
	(iv) If an adult individual is admission and is unable to r whether or not he or she has	incapacitated at the time	e of		1. R41 is discharged from the and has no ill effects from fa issue advance directive information.	ilure to	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 04/20/2023	ΣΥ
YORK NO	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IIP CODE:		
STATE LICENS	E NUMBER: 025602						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0578	Continued from page 2			F 0578			
SS=E	directive, the facility may g information to the individua accordance with State law. (v) The facility is not reliev this information to the individual receive such information. For place to provide the information appropriate time. This REQUIREMENT is not such as the place to provide the information appropriate time.	nd's resident representatived of its obligation to providual once he or she is a collow-up procedures mustion to the individual display.	ovide able to ast be in		upon admission. R70 and R1 currently reside in the facility have been provided with advidirective information. 2. Utilizing the Action Summareport; the Admissions Director/designee will review 10 new admissions who curreside in the facility, the opp to form an advance directive 3. To ensure the deficient produces not re-occur, the NHA/designee will educate Admissions Director and Admissions team on the Adradvance Directives Policy of before the date of compliance 4. Utilizing the Action Summareport, the NHA/designee with 5 new admissions per week to ensure advance directive information was provided. Fewer advances of the provided	y and yance mary y the last ently ortunity actice the missions n or e. mary ill audit x4 weeks Results	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:		
		395442				04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	ZIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0578 SS=E	Based on policy review staff interview, it was of failed to ensure each rean advanced directive for reviewed (Residents 41). Findings include: An advanced directive statement of a person's treatment, often includensure those wishes are person be unable to confidence of the person be unable to con	determined that the fesident the right to for for three of 30 resident, 70, and 130). is defined as a written wishes regarding maning a living will, maning a living will, maning a carried out should mmunicate them to a server, titled "Health Casision date March 1, 2 ith the individual's p	en edical de to the a doctor. re 2022, patient	F 0578			
	time of admission as to directive had been com accordance with state l representative of their	whether an advance apleted/executed in aw. Inform the patie	ent/patient				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
	395442 B. WING:				04/20/2023		
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0578 SS=E	prepare advance directive wish to formulate an advanced directive information had been prepresentative. Review of Resident 41 Resident was admitted 2023, with diagnosis the breakdown of muscle to into the blood that can obstructive pulmonary disease that block airfle breathe), and seizure disease that block airfle breathe), and seizure disease that block airfle breathe) are recorded to receive during serior 21, 2023. Further revier record failed to reveal and advanced directive information in the properties of the types of the receive during serior 21, 2023. Further revier record failed to reveal and advanced directive information in the properties of	dvance directive. Proprention and docume provided to the patient's clinical record reverse to the facility on Manatinclude rhabdomy issue that releases a damage he kidneys) disease (a group of ow and make it difficient isorder. 's clinical record reverse clinical record reverse their own care by medical order that helps were their own care by medical treatment the sillness) was dated the of Resident 41's comment of the provided that the sillness is the provided that the provided the provided that the provided that the provided the provided that	ealed the arch 20, yolysis (a protein , chronic lung cult to	F 0578			

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395442				04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0578 SS=E	Review of Resident 70 orders revealed diagnor (a lifelong condition in pump enough blood to blood and oxygen) and (A chronic condition the processes blood sugar With type 2 diabetes, the produce enough insuling Review of Resident 70 admission date of Marco Continued review of Resident and/or Residen	ses that included hear which the heart mu meet the body's need Diabetes Mellitus That affects the way the [glucose], he body either doesn, or it resists insuling the clinical record reversed 24, 2023. The sident 70's clinical regarding the facility presentative the opposed directive at admit the object of the compact o	art failure scle can't ds for Type II ne body I't). realed an record ity offering ortunity ssion or	F 0578			
	hypertension (elevated		anemia				

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		395442		A. BLDG: _ B. WING: _		04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: ORTH SKILLED NURSING ITATION CENTER SE NUMBER: 025602	AND	STREET ADDRESS 1770 BARLEY YORK, PA 17	Y ROAD	IP CODE:	1	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0578	Continued from page 6	ontinued from page 6					
SS=E	(a condition in which y blood cells to carry additissues). Review of Resident 13 admission date of Febro Continued review of Revealed no information the Resident and/or Resident and/or Resident and after. Interview on April 19, Director Of Nursing (I information pertaining directive is not review process. Interview on April 20, DON was informed of Resident 41 not being during the admission pertaining during	equate oxygen to you o's clinical record returns 6, 2023. desident 70's clinical on regarding the facility presentative the opposed directive at admit 2023, at 11:15 AM, DON) revealed that to formulating an acted during the admission 2023, at 10:45 AM, the concern regarding afforded the opportunation of the concern regarding afforded the opportunity of the concern regarding afforded the oppor	record ity offering ortunity ssion or with the dvanced ion				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		395442		B. WING: _		04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	ZIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	(X5) COMPLETE DATE			
F 0578	Continued from page 7			F 0578			
SS=E	advanced directive; no provided. 28 Pa. Code 211.5 (f) C 28 Pa. Code 201.18(a)(28 Pa. Code 201.29(a)	Clinical records. b)(1)(d)Managemer					
F 0583				F 0583			
F 0583 SS=D				F 0583			

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SUR COMPLETED:	VEY
		395442			<u></u>	04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: PRTH SKILLED NURSIN ITATION CENTER SE NUMBER: 025602	NG AND	STREET ADDRESS 1770 BARLE YORK, PA 1	Y ROAD	IP CODE:	1	
(X4) ID PREFIX TAG	X MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0583	Continued from page 8			F 0583			
SS=D	Records §483.10(h) Privacy and C The resident has a right to confidentiality of his or h §483.10(h)(1) Personal privacy and C medical treatment, writte personal care, visits, and groups, but this does not private room for each res §483.10(h)(2) The facility personal privacy, including oral (that is, spoken), write communications, including receive unopened mail and other materials delivered including those delivered postal service. §483.10(h)(3) The reside confidential personal and (i) The resident has the rite personal and medical receives \$483.70(i)(2) or other approximation (ii) The facility must allouthe State Long-Term Car	o personal privacy and ner personal and medical receivacy includes accommodan and telephone communication meetings of family and reserquire the facility to provident. The provident of the resident of the right to privacy in his ten, and electronication of the right to send and provident of the facility for the resident of the f	cords. ations, cations, cident ide a s right to is or her comptly and ent, an a		The statements made on the correction are not an admiss and do not constitute an agwith the alleged deficiency herein. To remain in complall federal and state regulate facility has taken, and will actions set forth in the folloplan of correction. The folloplan of correction constitute center's allegation of compalleged deficiencies cited hor will be corrected by the dates indicated. The facility committed to taking all actinecessary to remain in subscompliance with state and regulations. The plan of conaddresses our intention to prove for our residents which enhances their dignity and designed to meet their interpromote the highest practice of physical, mental, and psycho-social well-being. 1. Employee 3 was educate Genesis Personal Privacy Page 1.	ssion to reement (s) liance with ions, the take, the owing owing es the liance. All ave been, date or y is ions stantial federal rrection oromote h is rests and eable level	Completion Date: 06/06/2023 Status: APPROVED Date: 05/03/2023

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΞY
		395442		B. WING: _		04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: ORTH SKILLED NURSING ITATION CENTER	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IP CODE:		
(X4) ID	SE NUMBER: 025602	OF DEFICIENCIES (EACH DE	EICIENCV	ID	PROVIDERIC N. AN OF CORRE	OTION (FACIL	(X5)
PREFIX TAG	MUST BE PRECEEDI	ED BY FULL REGULATORY OF FYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE
F 0583	Continued from page 9			F 0583			
SS=D	accordance with State law. This REQUIREMENT is no	ot met as evidenced by:			2. Utilizing the current Patier report; the DON/designee will all current residents to ensure resident confidentiality is maintained. 3. To ensure the deficient pradoes not re-occur, the DON/designee will educate to Licensed Nursing Staff on the Genesis Personal Privacy Po F-tag 0583 on or before the compliance. 4. The DON/designee will at med passes per week x4 wee ensure resident confidentiality maintained. Results will be rewith QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	actice the ne solicy and date of udit 5 eks to ty is reviewed	

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/ PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER				PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	ΞY	
395442 A. BLDG:00_ B. WING:				04/20/2023			
YORK NO REHABILI	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER E NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0583	Continued from page 10			F 0583			
SS=D	Based on observation, policy review, it was defailed to ensure each reconfidentiality of his observen resident halls reversident halls rev	etermined that the fassident the right to r her medical record viewed (200 Hall). Spolicy, titled "Privated December 5, 2019 has a right to personal and continues "Personal perment"	for one of acy o, al privacy medical orivacy				
	An observation in the 2 at 12:34 PM, revealed by staff and to display information on the com An immediate observar assigned Employee 3 (found to be standing at	a medication cart un resident medical rec nputer screen. tion and interview v Licensed Practical N	attended ord with the Nurse),				

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/ PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			A. BLDG: _	PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED:	
		395442		B. WING: _		04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	ZIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OULD BE	(X5) COMPLETE DATE
F 0583 SS=D	the desk area, revealed my pen." The observation also reconversation with other an interview with the 18, 2023, at 11:44 AM medication cart should and resident medical rebe displayed. 28 Pa. Code 211.5 (b)	evealed Employee 3 r staff members. Director of Nursing , revealed an agreem not have been unattecord information sh	in on April nent the ended	F 0583			
F 0641 SS=D				F 0641			

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 395442		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURV COMPLETED: 04/20/2023	EY
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602		STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IIP CODE:			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 12 483.20(g) Accuracy of Assessates \$483.20(g) Accuracy of Assessment must accurate status. This REQUIREMENT is not	sessments. Itely reflect the resident	s	F 0641	The statements made on this correction are not an admission and do not constitute an agree with the alleged deficiency (herein. To remain in complia all federal and state regulation facility has taken, and will taxed actions set forth in the follow plan of correction. The follow plan of correction constitutes center's allegation of complia alleged deficiencies cited has or will be corrected by the did dates indicated. The facility committed to taking all action necessary to remain in substate compliance with state and fer regulations. The plan of corrected or intention to procare for our residents which enhances their dignity and is designed to meet their interest promote the highest practical of physical, mental, and psycho-social well-being.	ion to seement s) unce with ons, the ske, the wing wing s the ance. All we been, ate or is antial deral ection omote sts and ble level	Completion Date: 06/06/2023 Status: APPROVED Date: 05/03/2023
					1. R139 MDS from January will be corrected.	28, 2023	

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	MENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIED F CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	, ,	207442		A. BLDG: _ B. WING:	00	04/20/2023	
		395442		D. WING.		04/20/2023	
YORK NO	vider or supplier: RTH SKILLED NURSING ITATION CENTER	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IP CODE:		
KEHABILI	HAITON CENTER		YUKK, PA 17	400			
STATE LICENSE NUMBER: 025602							
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 13			F 0641			
SS=D							
					2. The RNAC/designee will the last 10 discharged assess to ensure accuracy.		
					3. To prevent the deficient p from recurrence the NHA/de		
					will educate the RNACs on and coding the accurate discistatus on or before the date of	F-tag 641 harge	
					4. The RNAC/designee will discharge assessments per w weeks to ensure accurate assessments. Results will be	eek x 4	
					reviewed with QAPI.		
					5. Facility alleges substantial compliance on June 6, 2023.		

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					(X3) DATE SURVEY COMPLETED:	
	395442				04/20/2023	
VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER E NUMBER: 025602	AND	1770 BARLEY	ROAD	ZIP CODE:		
			ID PREFIX TAG	CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE
it was determined that that the resident assess resident's status for one (Resident 139). Findings Include: Review of Resident 13 diagnoses that included pulmonary disease (a g block airflow and make gastro esophageal refluin which stomach acid lining). Review of Resident 13 is part of the federally assessment of all Medinursing homes) dated J that Section A2100 Dis "03. Acute hospital", si	9's clinical record red chronic obstructive group of lung disease it difficult to breath ax disease (a digestive or bile irritates the formal desired and Medicaid of January 28, 2023, rescharge Status was mignifying that Reside	ensure ected the iewed evealed es that he) and we disease cood pipe Data Set or clinical certified evealed narked ent 139	F 0641			
3						
	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER E NUMBER: 025602 SUMMARY STATEMENT MUST BE PRECEEDI IDENTI Continued from page 14 Based on clinical recor it was determined that that the resident assess resident's status for one (Resident 139). Findings Include: Review of Resident 13 diagnoses that included pulmonary disease (a g block airflow and mak gastro esophageal reflu in which stomach acid lining). Review of Resident 13 is part of the federally assessment of all Medi nursing homes) dated 3 that Section A2100 Dis "03. Acute hospital", s	VIDER OR SUPPLIER: RTH SKILLED NURSING AND ITATION CENTER E NUMBER: 025602 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION) Continued from page 14 Based on clinical record review and staff in it was determined that the facility failed to that the resident assessment accurately refleresident's status for one of 30 residents review (Resident 139). Findings Include: Review of Resident 139's clinical record rediagnoses that included chronic obstructive pulmonary disease (a group of lung disease block airflow and make it difficult to breat gastro esophageal reflux disease (a digestive in which stomach acid or bile irritates the filning). Review of Resident 139's MDS (Minimum is part of the federally mandated process for assessment of all Medicare and Medicaid conursing homes) dated January 28, 2023, retall that Section A2100 Discharge Status was refused to the section A2100	VIDER OR SUPPLIER: RTH SKILLED NURSING AND ITATION CENTER E NUMBER: 025602 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 14 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for one of 30 residents reviewed (Resident 139). Findings Include: Review of Resident 139's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and gastro esophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe	ID PREFIX TAG IDENTIFICATION NUMBER: 395442 STREET ADDRESS, CITY, STATE, 2 1770 BARLEY ROAD YORK, PA 17408 E NUMBER: 025602 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 14 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for one of 30 residents reviewed (Resident 139). Findings Include: Review of Resident 139's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and gastro esophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining). Review of Resident 139's MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated January 28, 2023, revealed that Section A2100 Discharge Status was marked "03. Acute hospital", signifying that Resident 139	IDENTIFICATION NUMBER: 395442 STREET ADDRESS, CITY, STATE, ZIP CODE: 1770 BARLEY ROAD YORK, PA 17408 SUMMARY STATEMENT OF DEFICIENCES (BACH) DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 14 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for one of 30 residents reviewed (Resident 139). Findings Include: Review of Resident 139's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and gastro esophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining). Review of Resident 139's MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated January 28, 2023, revealed that Section A2100 Discharge Status was marked "03. Acute hospital", signifying that Resident 139	A BLDG: 00 B WING. COMPLETED ADDRESS. CITY, STATE, JP CODE TO THE APPROPRIATE CONTINUED TO THE APPROPRI

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		395442		B. WING: _		04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	CIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 15			F 0641			
	Review of a nursing progress note dated January 28, 2023, at 1:02 PM, revealed that Resident 139 was discharged home with her husband.		-				
	Interview with the Director of Nursing on April 20, 2023, at 8:32 AM, revealed that the MDS was marked in error and that it will be corrected.		was				
	28 Pa. Code 211.5(f) C 28 Pa Code 211.12 (d)		ces				
F 0684				F 0684			
SS=E							

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	OF DEFICIENCIES AND RECTION (POC)	identification number 395442		A. BLDG: _	00	(X3) DATE SURVEY COMPLETED: 04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602		AND	STREET ADDRESS 1770 BARLE YORK, PA 1	Y ROAD	TIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0684 SS=E	Continued from page 16 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundame treatment and care provided the comprehensive assessment ensure that residents re accordance with professional comprehensive person-center residents' choices. This REQUIREMENT is no	I to facility residents. Batent of a resident, the faceceive treatment and caral standards of practice, ered care plan, and the	ised on ility e in	F 0684	The statements made on this correction are not an admission and do not constitute an agree with the alleged deficiency (herein. To remain in complication and state regulation facility has taken, and will take actions set forth in the follow plan of correction. The follow plan of correction constitutes center's allegation of complication alleged deficiencies cited has or will be corrected by the distance with state and for eight and the facility committed to taking all action necessary to remain in substate compliance with state and for regulations. The plan of corrected or corrected to the regulations of the regulations of the regulations of the regulation of the right paints of the ri	ion to beement s) ance with ons, the ake, the ving wing s the ance. All ve been, ate or is ons antial deral ection omote sts and ble level	Completion Date: 06/06/2023 Status: APPROVED Date: 05/03/2023

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUP IDENTIFICATION N		NUMBER:		IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395442				04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER E NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	ZIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIC PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR I TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0684	Continued from page 17			F 0684			
SS=E					2. Current residents that requisplint have been reviewed to the plan of care and physicial is accurately reflective of assidevices. 3. To prevent the deficient pure from recurrence the DON/de will educate the Licensed Nu Staff on ensuring MD orders obtained and care plan is upon or before the date of compliants. 4. The DON/designee will as residents that require a splint week x 4 weeks to ensure compliance. Results will be with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	ractice esignee cursing s are dated on ance. udit 5 t per reviewed	

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Name of Provider or Stappler: 170 BARLEY ROAD 1770 BARLEY ROAD	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER				IPLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	EY	
TORK NORTH SKILLED NURSING AND REHABILITATION CENTER 1776 BARLEY ROAD YORK, PA 17408			395442				04/20/2023	
CX4 ID PREPIX TAG	YORK NORTH SKILLED NURSING AND REHABILITATION CENTER			1770 BARLEY	ROAD	ZIP CODE:		
Based on review of the clinical record, observations, and staff interview, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of 30 residents reviewed (Resident 109). Findings include: Review of Resident 109's clinical record documented diagnoses that included cerebral vascular accident (CVA- stroke damage to the brain from interruption of its blood supply) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following CVA on the right,	(X4) ID PREFIX	SUMMARY STATEMENT MUST BE PRECEEDE	ED BY FULL REGULATORY O			CORRECTIVE ACTION SH	OULD BE	COMPLETE
Observation of Resident 109 on April 17th, 2023, at 11:47 AM; April 18th, 2023, at 12:30 PM; and April 19th, 2023, at 10:30 AM revealed Resident 109 was wearing a right palm protector.		Based on review of the and staff interview, it was failed to ensure care an accordance with profess that will meet each resist psychosocial needs for (Resident 109). Findings include: Review of Resident 10 documented diagnoses vascular accident (CVA brain from interruption hemiparesis (muscle woon one side of the body legs, and facial muscle dominant side. Observation of Resider at 11:47 AM; April 186 April 19th, 2023, at 10	was determined that and services were prosisional standards of pident's physical, mer one of 30 residents 9's clinical record that included cerebrates to a fits blood supply) teakness or partial pay that can affect the ass) following CVA of the theorem of the	the facility vided in practice atal, and reviewed and aralysis arms, an the right, 2023, M; and	F 0684			

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395442		1	00	04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	TIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 19			F 0684			
SS=E							
	Review of Resident 10		-				
	2023 medication and tr						
	records (a record of me were administered) fail						
	protector and/or skin e	•					
	protector una, or skin c	variations of the rigi	iit iidiid.				
	Review of tasks docum	nentation revealed a					
	restorative program for	ambulation; howev	er, there				
	wasn't documentation to	•					
	protector/splinting prog	gram.					
	Review of Resident 109's care plan read, in part, activities of daily living self-care deficit due to CV with an initiated date of February 11, 2022. Interventions included a right palm protector may remove for hygiene, with an initiated date of February 18, 2022; ambulate up to 50 feet with rolling walker, gait belt, and one person assist, wir an initiated date of December 29, 2022; and active range of motion of upper and lower extremities 10 repetitions each during activities of daily living two daily, with an initiated date of March 2, 2022.						

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	EMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	. ,	395442		A. BLDG: <u>00</u> B. WING:		04/20/2023	
		395442					
	NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND			, CITY, STATE, Z Y ROAD	IIP CODE:		
REHABIL	ITATION CENTER		YORK, PA 1	7408			
STATE LICENS	E NUMBER: 025602						
(X4) ID		OF DEFICIENCIES (EACH DE		ID DREELY TAG	PROVIDER'S PLAN OF CORRE	,	(X5) COMPLETE
PREFIX TAG		ED BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE		DATE
F 0684	Continued from page 20			F 0684			
SS=E							
55 E							
	Review of Resident 10	9's kardex (a quick i	eference				
	of a resident's care nee	ds) read, in part, rest	torative				
	active range of motion	* *					
	extremities (10 repetiti						
	daily living twice daily		•				
	50 feet with a rolling w	, 0					
	person assist; and right remove for hygiene.	nand paim protecto	r, may				
	remove for hygiene.						
	Review of Resident 10	9's Restorative Nurs	ing				
	Status Assessment date	ed February 14, 2023	3,				
	documented range of n						
	restorative care needs, and no documentation of		on of				
	splint or brace assistance.						
	Interview on April 20,	2023, at 10:30 AM,	the				
	Director of Nursing (D	ON) was informed of	of the				
	concerns that Resident						
	physician order for the						
	in place to monitor for						
	protector, monitoring f						
	restorative assessment	not incorporating th	e use of				

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	Γ OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER DRRECTION (POC) IDENTIFICATION NUMBI			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:			
		205442			00	04/20/2023			
		395442				04/20/2023			
	VIDER OR SUPPLIER: RTH SKILLED NURSING	AND	STREET ADDRESS, CITY, STATE, ZIP CODE: 1770 BARLEY ROAD						
	ITATION CENTER	THE	YORK, PA 17408						
STATE LICENSE NUMBER: 025602									
(X4) ID		OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (FACH	(X5)		
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY O		PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	COMPLETE		
TAG	IDENTI	FYING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE		
F 0684	Continued from page 21			F 0684					
SS=E									
33-E	the palm protector. DO	N stated that theran	v would						
	assess the Resident for								
	and provide nursing gu								
	obtained and monitoring								
	nursing to complete.								
	Interview of April 20,	2023, at 11:51 AM,	with the						
	DON revealed that, as	of March 2, 2022, R	esident						
	109 was care planned f	for the use of the pal	m						
	protector, and that ther	e should've been a p	hysician						
	order for use of the pal	m protector and mor	nitoring						
	for skin integrity.								
	28 Pa. Code 201.18(b)	` '							
	28 Pa. Code 211.12(d)	(1)(5) Nursing service	ces						
F 0686				F 0686					
SS=D									

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		A. BLDG:	00	COMPLETED:	
395442		B. WING:		04/20/2023	
AND	1770 BARLE	Y ROAD	IP CODE:		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
ers. e assessment of a reside consistent with professivent pressure ulcers and unless the individual's c they were unavoidable; c ulcers receives necessa sistent with professiona mote healing, prevent in n developing.	nt, the ional I does clinical and ary	F 0686	correction are not an admission and do not constitute an agree with the alleged deficiency (herein. To remain in complication all federal and state regulation facility has taken, and will tate actions set forth in the follow plan of correction. The follow plan of correction constitutes center's allegation of complication alleged deficiencies cited has or will be corrected by the did dates indicated. The facility committed to taking all action necessary to remain in substate compliance with state and feregulations. The plan of corrected or underesses our intention to procare for our residents which enhances their dignity and is designed to meet their interest promote the highest practication of physical, mental, and psycho-social well-being. 1. R106 resides in the facility no ill effects from wound tree.	ion to eement s) ance with ons, the ake, the wing wing s the ance. All we been, ate or is ons antial deral ection omote sts and ble level	Completion Date: 06/06/2023 Status: APPROVED Date: 05/08/2023
	395442 GAND TOF DEFICIENCIES (EACH DEED BY FULL REGULATORY OF FYING INFORMATION) The second of a residency of the second o	STREET ADDRESS 1770 BARLET YORK, PA 1 TOF DEFICIENCIES (EACH DEFICIENCY ED BY FULL REGULATORY OR LSC FYING INFORMATION) THE STREET ADDRESS 1770 BARLET YORK, PA 1 TOF DEFICIENCIES (EACH DEFICIENCY ED BY FULL REGULATORY OR LSC FYING INFORMATION) THE STREET ADDRESS 1770 BARLET YORK, PA 1 TOF DEFICIENCIES (EACH DEFICIENCY ED BARLET YORK, PA 1 TOF DEFICIENCIES (EACH DEFICIENCY ED BARLET YORK, PA 1 TOF DEFICIENCIES (EACH DEFICIENCY ED BARLET YORK, PA 1 TOF DEFICIENCIES (EACH DEFICIENCY ED BARLET YORK, PA 1 TOF DEFICIENCIES (EACH DEFICIENCY ED BARLET YORK, PA 1 TOF DEFICIENCIES (EACH DEFICIENCY ED BARLET YORK, PA 1 TOF DEFICIENC	A. BLDG: _B. WING:	A BLDG:00	A BLDG: 00 B WING:

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	R: A. BLDG: _		IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395442		B. WING: _		04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	.IP CODE:		
STATE LICENS (X4) ID	E NUMBER: 025602 SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY OF		PREFIX TAG	CORRECTIVE ACTION SHE	OULD BE	COMPLETE DATE
F 0686	Continued from page 23			F 0686			
SS=D					wound treatment process. 2. The DON/designee will correcord review of 10 residents require wound treatments to compliance to facility policy promote healing and prevent infection. 3. To prevent the deficient process of the wound treatment process on or before the date compliance. 4. The DON/designee will audit/observe 5 resident wou treatments per week x 4 wee ensure compliance. Results reviewed with QAPI. 5. Facility alleges substantial compliance on June 6, 2023.	s who ensure to to to tractice esignee eursing tt e of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/20/2023	
		395442				04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER			1770 BARLEY YORK, PA 17	ROAD	XIP CODE:		
i	TE LICENSE NUMBER: 025602				<u></u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0686	Continued from page 24			F 0686			
SS=D							
	Based on clinical recor		-				
	interview, and facility						
	determined that the fac treatment and services						
	prevent infection were						
	residents observed for	-					
	(Resident 106).	C					
	Findings include:						
	Review of facility police	cy, titled "NSG241					
	Treatments," last revise	ed June 1, 2021, rev	ealed it				
	was the facility's policy						
	medical technician, per	•					
	perform ordered treatm practice will be followed	•					
	•		-				
	purpose was, "To provide a safe and effect administration of treatments."		140				
	Review of Resident 10		•				
	18, 2023, at approxima	•					
	diagnoses including de						
	progressive degenerative	ve disease of the bra	ın that				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTI A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
		395442		B. WING:		04/20/2023	
YORK NO REHABIL	NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			CITY, STATE, Z Y ROAD 7408	IP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0686 SS=D	results in decreased coordecreased ability to per and a stage 4 pressure extends to the underlyitissue, which is the restarea). During wound treatme 2023, at approximately observed preparing Resupplies at the treatmer After Employee 4 had prepared, Employee 4 gloves, after which, Ensupplies and started to room. While walking to Resident control of the control of	rform activities of daulcer (injury of the surface) and/or consult of pressure over a surface of the surface of	hily living) kin that hective he bony bril 19, he 4 was ht hallway. hallway. helies hallway helies hallway helies hallway	F 0686			
	While walking to Resident 106's room Employee 4 was observed dropping an extra pair of gloves on the floor. Employee 4 then used her gloved hands to pick up the extra pair of gloves off the floor and discarded them into a trash can. Employee 4 then proceeded to enter Resident 106's room.		ves on d hands oor and				

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		identification number 395442		A. BLDG: _ B. WING: _		COMPLETED: 04/20/2023	5 Y
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	MP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0686 SS=D	Once at Resident 106's removed Resident 106' wound dressing, and claperforming hand hygie that were donned in the After removing the price wound dressing and classing and cla	s prior stage 4 press eansed the wound we not changing the e hallway. For stage 4 pressure use eansing the wound, I new pair of gloves; afform hand hygiene eyee 4 was then observed cream to the perfect that the perfect stage 4 pressure usensing the ordered by a finger, Employee englasses, located on Imployee then dispensions.	ure ulcer without gloves ulcer Employee however, between rved ri-wound lcer) earrier 4 was her face, ised the	F 0686			
	proceeded to apply the area. After touching he peri-wound barrier crea gloves or performing h	cream to the peri-wer glasses and applying am and without char	ound ing the nging				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395442		A. BLDG: _ B. WING: _		04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER SE NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 1	ROAD	MP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
F 0686	Continued from page 27			F 0686			
SS=D	observed handling and dressing with her right subsequently inserted to into Resident 106's stated. After applying a foam Employee 4 removed hashe was finished with to During a staff interview approximately 11:30 A revealed it was the fact perform hand hygiene accessing a resident's work of a dressing, cleansing applying a new dressing 28 Pa. Code 211.12(d)	gloved hand. Empleiche collagen wound of ge 4 pressure ulcer. dressing to the wounder gloves and confine the dressing change. W on April 20, 2023, a.M., Director of Nursility's expectation that and don new gloves wound and between a g a wound, and prior ag.	oyee 4 dressing nd, rmed that at sing at staff prior to removal				
F 0689				F 0689			
SS=D							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 395442			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00_ B. WING:		(X3) DATE SURVEY COMPLETED: 04/20/2023		
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602		STREET ADDRESS, 1770 BARLEY YORK, PA 17	, CITY, STATE, Z				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE AP		OULD BE	(X5) COMPLETE DATE
F 0689	Continued from page 28			F 0689			
SS=D	483.25(d)(1)(2) Free of Acc Hazards/Supervision/Device \$483.25(d) Accidents. The facility must ensure tha \$483.25(d)(1) The resident accident hazards as is possil \$483.25(d)(2)Each resident and assistance devices to pr	t - environment remains as ble; and receives adequate super event accidents.			The statements made on this correction are not an admission and do not constitute an agree with the alleged deficiency (herein. To remain in complicate all federal and state regulation facility has taken, and will take actions set forth in the follow plan of correction. The follow plan of correction constitutes center's allegation of complicated deficiencies cited has or will be corrected by the dates indicated. The facility committed to taking all action necessary to remain in substate compliance with state and feregulations. The plan of corrected or our residents which enhances their dignity and is designed to meet their interest promote the highest practicate of physical, mental, and psycho-social well-being. 1. Employee 3 was educated General Dose Preparation and Medication Administration presents.	ion to element s) ance with ons, the ake, the wing wing s the ance. All we been, ate or is ons antial deral election omote sts and ble level	Completion Date: 06/06/2023 Status: APPROVED Date: 05/08/2023

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: _00		(X3) DATE SURVEY COMPLETED:		
		395442		B. WING: 04/20/2023				
YORK NO REHABILI	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER E NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IIP CODE:			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE	
F 0689	Continued from page 29			F 0689				
SS=D					 The DON/designee will of a direct observation of med pto ensure medications are not unattended and the med cart secured. To prevent the deficient property of the DON/designee will educate a Licensed Nursing staff on the General Dose Preparation and Medication Administration probefore the date of compliants. The DON/designee will at resident's med passes throug observation per week x 4 we ensure compliance. Results reviewed with QAPI. Facility alleges substantial compliance on June 6, 2023. 	passes t left is ractice the e ad policy on ance. udit 5 th direct teks to will be		

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		identification number 395442		A. BLDG: _	00	COMPLETED: 04/20/2023	5 Y
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS 1770 BARLEY YORK, PA 1	Y ROAD	IP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0689 SS=D	Based on observation, staff interview, it was of failed to ensure a reside of accident hazards for reviewed (200 Hall). Findings Include: Review of the facility's Preparation and Medicarecently revised Januar "Facility staff shall not chemicals unattended." An observation on Aprarevealed an unattended Hall with several insuling medication. An immediate observation assigned Employee 3 (found to be standing at the desk area, revealed)	determined that the fent environment remone of seven reside spolicy, titled "Generation Administration by 1, 2022, reads, in leave medications of the medication cart in the fin pens and one cup tion and interview where the control of the control	eral Dose n", part, or PM, the 200 containing with the Nurse), behind	F 0689			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED:	
		395442		B. WING: _	<u></u>	04/20/2023	
YORK NO REHABILI	NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			CITY, STATE, Z Y ROAD 7408	IIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0689	Continued from page 31			F 0689			
SS=D	my pen." The observation also reconversation with other		in				
An interview with the Director of Nursing, 18, 2023, at 11:44 AM, revealed an agreem medication cart, with medications present, anot have been unattended by Employee 3.			nent the				
F 0730	211.12 (d) (1) (2) Nurs	ing services		E 0720			
F 0730 SS=E				F 0730			

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		identification number 395442		A. BLDG:	00	(X3) DATE SURVEY COMPLETED: 04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER SEE NUMBER: 025602	AND	STREET ADDRESS 1770 BARLE YORK, PA 1	Y ROAD	IP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG			(X5) COMPLETE DATE
F 0730 SS=E	Continued from page 32 483.35(d)(7) Nurse Aide Pe §483.35(d)(7) Regular in-se The facility must complete nurse aide at least once ever regular in-service education reviews. In-service training requirements of §483.95(g). This REQUIREMENT is no	ervice education. a performance review of ry 12 months, and must based on the outcome of must comply with the	f every provide	F 0730	The statements made on this correction are not an admiss and do not constitute an agree with the alleged deficiency (herein. To remain in complication of correction and will target actions set forth in the following plan of correction. The following plan of correction constitutes center's allegation of complication alleged deficiencies cited has or will be corrected by the distribution of the deficiency of the distribution	ion to element (s) ance with ons, the ake, the wing wing s the ance. All ve been, ate or is ons antial election comote sests and able level	Completion Date: 06/06/2023 Status: APPROVED Date: 05/03/2023

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:			
		395442	A. BLDG:00 B. WING: 04/20/2023						
		395442				0.1/20/2020			
	VIDER OR SUPPLIER: RTH SKILLED NURSING	AND	STREET ADDRESS, CITY, STATE, ZIP CODE: 1770 BARLEY ROAD						
REHABILI	TATION CENTER		YORK, PA 17	7408					
STATE LICENS	e number: 025602								
(X4) ID	SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE		ID	PROVIDER'S PLAN OF CORRECT		(X5)		
PREFIX MUST BE PRECEEDED BY FULL REGULATORY C TAG IDENTIFYING INFORMATION)		R LSC	PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A		COMPLETE DATE			
F 0730	Continued from page 33			F 0720					
г 0/30	Continued from page 33			F 0730					
SS=E									
					reviews.				
					2. The HRD/designee will co	omplete a			
					review of current employee				
					ensure annual performance r were completed and up to da				
					3. To prevent the deficient prefrom re-occurrence the	ractice			
					NHA/designee will educate to	the HRD			
					and Payroll on F-tag 0730 or	ı or			
					before the date of complianc	e.			
					4. The HRD/designee will at	ıdit 5			
					employee files per week x 4				
					ensure compliance. Results reviewed with QAPI.	will be			
					5. Facility alleges substantial compliance on June 6, 2023.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395442		A. BLDG: _ B. WING: _		04/20/2023	
YORK NO REHABILI	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER E NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IIP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0730	Continued from page 34			F 0730			
SS=E	Based on document reviews determined that the annual performance receives aide for three of reviews documented (In Findings Include: Review of Employee 5 review revealed a date. Review of Employees review revealed a date. Review of Employees review revealed a date. An interview with the 19, 2023, at 2:07 PM, of performance reviews for employees were not contact.	e facility failed to enview is completed for five nurse aide performance of January 13, 2022 6's most recent performance of October 14, 2021 Director of Nursing, confirmed the annual or the aforementione empleted on an annual properties of the performance of the performance of the aforementione of the aforemention of the a	rmance . cmance . cmance . cmance . cmance . cmance . do April l ed al basis.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395442		B. WING:		04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602			STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY CONTROL TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0803				F 0803			
SS=E							

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PLAN OF CORRECTION (POC) ID		IDENTIFICATION NUMBER:		A. BLDG: _	(X2) MULTIPLE CONSTRUCTION: A. BLDG:00_ B. WING:		(X3) DATE SURVEY COMPLETED:	
		395442		B. WING.		04/20/2023		
	OVIDER OR SUPPLIER: DRTH SKILLED NURSING	G AND	STREET ADDRESS 1770 BARLEY	Y ROAD	ZIP CODE:			
REHABIL	ITATION CENTER		YORK, PA 1	7408				
STATE LICEN	SE NUMBER: 025602							
(X4) ID		OF DEFICIENCIES (EACH DE			PROVIDER'S PLAN OF CORRECTION (EACH		(X5)	
PREFIX TAG		ED BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .		COMPLETE DATE	
							I P	
F 0803	Continued from page 36			F 0803				
SS=E								
	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in						Completion	
	Adv/Followed			The statements made on this	•	Date:		
	0.400.60() 3.5			correction are not an admiss		06/06/2023 Status:		
	§483.60(c) Menus and nutri			and do not constitute an agree		APPROVED		
	Menus must-			with the alleged deficiency (herein. To remain in compli-		Date:		
	8483 60(c)(1) Meet the nutr	s in		all federal and state regulation		05/03/2023		
	§483.60(c)(1) Meet the nutritional needs of resident accordance with established national guidelines.;				facility has taken, and will ta			
		a navional garacinico.,			actions set forth in the follow			
	§483.60(c)(2) Be prepared in	in advance;			plan of correction. The follo	wing		
					plan of correction constitute			
	§483.60(c)(3) Be followed;				center's allegation of compli			
	8402 (O()(A) D C + 1	1 6 77 1 1	1		alleged deficiencies cited ha			
	§483.60(c)(4) Reflect, based efforts, the religious, culturate				or will be corrected by the d dates indicated. The facility			
	resident population, as well		е		committed to taking all action			
	residents and resident group	-			necessary to remain in subst			
	Testaents and restaent group	,			compliance with state and fe			
	§483.60(c)(5) Be updated p	eriodically;			regulations. The plan of corr			
		3 /			addresses our intention to pr			
	§483.60(c)(6) Be reviewed	by the facility's dietitian	or other		care for our residents which			
	clinically qualified nutrition	n professional for nutrition	onal		enhances their dignity and is	5		
	adequacy; and				designed to meet their intere			
					promote the highest practica	ble level		
	§483.60(c)(7) Nothing in th				of physical, mental, and			
	construed to limit the reside	ent's right to make person	nal		psycho-social well-being.			
	dietary choices.				1 D1051 31 00 0	C :1		
	TI: DECLUSES COM:				1. R105 has no ill effects fro	m failure		
	This REQUIREMENT is no	ot met as evidenced by:			to provide garlic bread.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395442				04/20/2023	
YORK NO REHABILI	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	ZIP CODE:		
STATE LICENS (X4) ID	E NUMBER: 025602 SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE	FICIENCY	ID	PROVIDER'S PLAN OF CORRE	CTION (FACH	(X5)
PREFIX TAG	MUST BE PRECEEDE IDENTII		PREFIX TAG	CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	COMPLETE DATE	
F 0803	Continued from page 37			F 0803			
SS=E			fagility History History		 The Dietician/designee withe menus to ensure tray acc To prevent the deficient p from re-occurrence the Dietitian/designee will educa Dietary staff on Menu and traccuracy on or before the decompliance. The Dietitian/designee witrays per week x 4 weeks to compliance. Results will be with QAPI. Facility alleges substantia compliance on June 6, 2023. 	uracy. ractice ate the ray ate of Il audit 5 ensure reviewed	
F 0880				F 0880			
SS=D							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395442			00	04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: IRTH SKILLED NURSING ITATION CENTER SE NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	CIP CODE:		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OR LSC			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0880	Continued from page 38			F 0880			
SS=D	483.80(a)(1)(2)(4)(e)(f) Inference \$483.80 Infection Control The facility must establish a prevention and control prog sanitary and comfortable enthe development and transmit diseases and infections. §483.80(a) Infection preventhe facility must establish a control program (IPCP) that following elements: §483.80(a)(1) A system for reporting, investigating, and communicable diseases for visitors, and other individual contractual arrangement bas assessment conducted accorfollowing accepted national §483.80(a)(2) Written stand for the program, which mus (i) A system of surveillance communicable diseases or infections before they can spacility; (ii) When and to whom possidisease or infections should	and maintain an infection ram designed to provide vironment and to help puission of communicable tion and control program in infection prevention as must include, at a minimus preventing, identifying, a controlling infections a fall residents, staff, volumed upon the facility ding to §483.70(e) and standards; ards, policies, and proceed tinclude, but are not limit designed to identify posterioread to other persons in sible incidents of communications.	n e a safe, revent e e a safe, revent e e e e e e e e e e e e e e e e e e		The statements made on this correction are not an admission and do not constitute an agree with the alleged deficiency (herein. To remain in complicate all federal and state regulation facility has taken, and will take actions set forth in the follow plan of correction. The follow plan of correction constitutes center's allegation of complicated deficiencies cited has or will be corrected by the dates indicated. The facility committed to taking all action necessary to remain in substate compliance with state and feregulations. The plan of corrected or our residents which enhances their dignity and is designed to meet their interest promote the highest practicate of physical, mental, and psycho-social well-being. 1. Employee 4 was educated Infection Control hand hygicapractices.	ion to beement s) ance with ons, the ake, the ving wing s the ance. All ve been, ate or is ons antial deral ection omote sts and ble level	Completion Date: 06/06/2023 Status: APPROVED Date: 05/08/2023

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	OF DEFICIENCIES AND RECTION (POC)	identification number. 395442		A. BLDG: _			5 Y
YORK NO REHABILI	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER E NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	ZIP CODE:		
(X4) ID		OF DEFICIENCIES (EACH DE	EICIENCY	ID	PROVIDER'S PLAN OF CORREC	CTION (FACIL	(X5)
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIEN MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE DATE
F 0880	Continued from page 39			F 0880			
SS=D	(iii) Standard and transmissi	ion-based precautions to	be be				
	followed to prevent spread of infections;				2. The DON/designee will co	omplete a	
	(iv)When and how isolation should be used for a resident;				record review of 10 residents		
	including but not limited to:				require wound treatments to		
	(A) The type and duration of the isolation, depending up				hand hygiene practices are b	eing	
	the infectious agent or organism involved, and				followed.		
	(B) A requirement that the isolation should be the least restrictive possible for the resident under the				3. To prevent the deficient p	ractice	
	circumstances.	esident under the			from recurrence the DON/de		
	(v) The circumstances under	r which the facility must	t		will educate the Licensed Nu	-	
	prohibit employees with a c				Staff on the infection control hand		
	infected skin lesions from d				hygiene practices on or before		
	their food, if direct contact v				date of compliance.		
	(vi)The hand hygiene proce				•		
	involved in direct resident c	ontact.			4. The DON/designee will a	ıdit 5	
					resident wound treatments th	-	
	§483.80(a)(4) A system for				direct observation per week		
	under the facility's IPCP and	d the corrective actions t	taken by		weeks to ensure compliance.		
	the facility.				Results will be reviewed wit	h QAPI	
	§483.80(e) Linens.		1:		5. Facility alleges substantia		
	Personnel must handle, store so as to prevent the spread of		linens		compliance on June 6, 2023.		
	§483.80(f) Annual review.		an I				
	The facility will conduct an		CP and				
	update their program, as nec	cessary.					
	This REQUIREMENT is no	ot met as evidenced by:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395442				04/20/2023	
YORK NO	VIDER OR SUPPLIER: RTH SKILLED NURSING TATION CENTER		STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IP CODE:		
	E NUMBER: 025602				<u> </u>		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEI ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0880	Continued from page 40			F 0880			
SS=D							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395442				04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER JEEN NUMBER: 025602	SAND	STREET ADDRESS 1770 BARLEY YORK, PA 17	ROAD	TIP CODE:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0880	Continued from page 41	ntinued from page 41					
SS=D	Based on observation a determined that the fact infection control hand prevent the developme communicable disease treatment carts observed. Findings include: After observing Employdressing change on Apapproximately 1:00 PN exiting the resident roccontaining treatment succontaining treatment succontaining soiled used cloth towel. Employee bag of soiled dressing supplies in her left han her right hand. Employee 4 was obserutility room. Employee towel in a laundry bin and the state of the fact	eility failed to maintal hygiene practices to ent of and transmission and infections for oned (600 Hall treatment) by the desired of the desired treatment of the desired t	ain proper help on of ne of one nt cart). und observed g g nd a small lding the ent towel in t's soiled hall cloth				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		395442		A. BLDG: _ B. WING: _	00	04/20/2023	
YORK NO REHABIL	VIDER OR SUPPLIER: ORTH SKILLED NURSING ITATION CENTER SE NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IIP CODE:		
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0880	Continued from page 42			F 0880			
SS=D	room. Employee 4 still dressing material and be her left hand as she was utility room. Employee accessing the bag with an open collagen dressing Employee 4 was then of the remaining treatment drawer. Employee there to remove the open collagend it inside the bag separate drawer. Employee 4 was observed and handling the treatment and handling the treatment of the performing hand hygien bag of soiled treatment. During a staff interview approximately 11:00 A revealed it was the facility.	bag of treatment supply sobserved exiting the 4 was then observed treatment supplies, and placed packet, and placed packet in the bottom observed placing the at supplies in a separal accessed the bottom lagen dressing packet, with treatment supplies after soiled utility room one, and also while he supplies. We on April 20, 2023, a.M., Director of Nurse.	polies in the soiled and removing ting the an drawer that and tolies in the therefore a the soile and the the soile and the soile and the therefore a the soile and the the soile and the soile and the soile and the the soile and the soile and the soile and the the soile and the soile and the soile and the the soile and the soile and the soile and the the so				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395442				04/20/2023	
YORK NO REHABILI	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER E NUMBER: 025602	AND	STREET ADDRESS, 1770 BARLEY YORK, PA 17	ROAD	IP CODE:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEI PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0880	Continued from page 43			F 0880			
SS=D	Employee 4 should have after accessing the soil accessing the treatment 28 Pa. Code 211.12(d)	ed utility room and t t cart.	hen				
F 0947				F 0947			
SS=E							

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		1 /	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395442			<u></u>	04/20/2023	
NAME OF PROVIDER OR SUPPLIER: YORK NORTH SKILLED NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 025602		STREET ADDRES 1770 BARLE YORK, PA	EY ROAD	IIP CODE:			
(X4) ID PREFIX TAG	REFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0947	Continued from page 44			F 0947			
SS=E	483.95(g)(1)-(4) Required Aides §483.95(g) Required in-se In-service training must- §483.95(g)(1) Be sufficier competence of nurse aides hours per year. §483.95(g)(2) Include den resident abuse prevention §483.95(g)(3) Address are nurse aides' performance r § 483.70(e) and may address a determined by the facility as determined by the facility as determined by the cognitive care of the cognitively important of the cognitive cognitive cognitively important of the cognitive	nt to ensure the continuing s, but must be no less than the nential management training training. The sease of weakness as determined the sease of weakness as determined to the sease of the sease the special needs of rest the staff. The sease of the	ides. 2 12 ng and iined in sment at sidents		The statements made on this correction are not an admiss and do not constitute an agre with the alleged deficiency (herein. To remain in compliall federal and state regulation facility has taken, and will tractions set forth in the follow plan of correction. The follow plan of correction constitute center's allegation of complialleged deficiencies cited has or will be corrected by the didates indicated. The facility committed to taking all action necessary to remain in substitute compliance with state and for regulations. The plan of corrected or our residents which enhances their dignity and is designed to meet their interest promote the highest practical of physical, mental, and psycho-social well-being. 1. Employees 8 and 9 were concompleting annual 12 hou aide training requirements.	sion to eement (s) ance with ons, the ake, the wing owing so the iance. All ave been, late or is ons cantial ederal rection romote	Completion Date: 06/06/2023 Status: APPROVED Date: 05/03/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	, ,	205442		A. BLDG: _ B. WING:	00	04/20/2023	
		395442				04/20/2025	
	VIDER OR SUPPLIER: RTH SKILLED NURSING	AND	STREET ADDRESS, 1770 BARLEY		IP CODE:		
	TATION CENTER		YORK, PA 17				
STATE LICENSI	e number: 025602						
(X4) ID	SUMMARY STATEMENT	OF DEFICIENCIES (EACH DE		ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)
PREFIX TAG		ED BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A		COMPLETE DATE
F 0947	Continued from page 45			F 0947			
SS=E							
					2. The HRD/designee will coreview of current CNA train		
					transcripts to ensure training	-	
					track for the year.		
					3. To prevent the deficient p	ractice	
					from recurrence the NHA/de	esignee	
					will educate the HRD on F-t on or before the date of com		
					on or before the date of com	priarice.	
					4. The HRD/designee will at		
					employee transcripts per wee weeks to ensure compliance.		
					Results will be reviewed wit		
					5. Facility alleges substantia	1	
					compliance on June 6, 2023.		

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OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395442		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/20/2023	
ITATION CENTER	AND	1770 BARLEY	ROAD	IP CODE:		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIE			ID PREFIX TAG	CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE
Continued from page 46			F 0947			
was determined that the required in-service trait than 12 hours per year training hours reviewed. Findings Include: Review of the facility's aide training hours for revealed the total number required 12 hours. An interview with the 20, 2023, at 8:54 AM, 9 did not complete the training.	e facility failed to en ning for nurse aides for two of five nurse d (Employees 8 and s documented annual Employee 8 and Em ber to be less than the Director of Nursing, confirmed Employee required 12 hours of	nsure the is no less e aide 9). I nurse aployee 9 e on April es 8 and				
28 Pa. Code 201.20 (c)	Staff development					
	VIDER OR SUPPLIER: RTH SKILLED NURSING ITATION CENTER E NUMBER: 025602 SUMMARY STATEMENT MUST BE PRECEEDI IDENTI Continued from page 46 Based on document rev was determined that th required in-service trai than 12 hours per year training hours reviewe Findings Include: Review of the facility's aide training hours for revealed the total numl required 12 hours. An interview with the 20, 2023, at 8:54 AM, 9 did not complete the training.	IDENTIFICATION NUMBERS: 395442 VIDER OR SUPPLIER: RTH SKILLED NURSING AND ITATION CENTER E NUMBER: 025602 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) Continued from page 46 Based on document review and staff interv was determined that the facility failed to enterquired in-service training for nurse aides than 12 hours per year for two of five nurse training hours reviewed (Employees 8 and Findings Include: Review of the facility's documented annual aide training hours for Employee 8 and Emtrevealed the total number to be less than the required 12 hours. An interview with the Director of Nursing, 20, 2023, at 8:54 AM, confirmed Employee 9 did not complete the required 12 hours of	WIDER OR SUPPLIER: RTH SKILLED NURSING AND ITATION CENTER E NUMBER: 025602 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 46 Based on document review and staff interview, it was determined that the facility failed to ensure the required in-service training for nurse aides is no less than 12 hours per year for two of five nurse aide training hours reviewed (Employees 8 and 9). Findings Include: Review of the facility's documented annual nurse aide training hours for Employee 8 and Employee 9 revealed the total number to be less than the required 12 hours. An interview with the Director of Nursing, on April 20, 2023, at 8:54 AM, confirmed Employees 8 and 9 did not complete the required 12 hours of annual training.	VIDER OR SUPPLIER: RTH SKILLED NURSING AND ITATION CENTER ENUMBER: 025602 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 46 Based on document review and staff interview, it was determined that the facility failed to ensure the required in-service training for nurse aides is no less than 12 hours per year for two of five nurse aide training hours reviewed (Employees 8 and 9). Findings Include: Review of the facility's documented annual nurse aide training hours for Employee 8 and Employee 9 revealed the total number to be less than the required 12 hours. An interview with the Director of Nursing, on April 20, 2023, at 8:54 AM, confirmed Employees 8 and 9 did not complete the required 12 hours of annual training.	DENTIFICATION NUMBER: 395442 A BLDG:00	STREET ADDRESS, CITY, STATE, ZIP CODE: 1770 BARLEY ROAD YORK, PA 17408

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Certified End Page

YORK NORTH SKILLED NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 025602 SURVEY EXIT DATE: 04/20/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY